Cultural differences are some of the most subtle, yet critical, factors affecting how people with Medicare understand their benefits, rights and choices. This brief explores the lessons we have learned from an effort to develop and test Medicare education materials suitable for audiences of varying cultural backgrounds.

Special thanks to the teams from the National Asian Pacific Center on Aging and The Spanish Speaking Elderly Council-RAICES for their work on this project.

Why Create Specialized Materials?

The 1997 Balanced Budget Act created the Medicare+Choice program, which transformed people with Medicare from “beneficiaries” into “consumers.” Rather than simply qualifying for and then receiving Medicare benefits, people over age 65 and some younger adults with disabilities may now have to make informed choices from different Medicare insurance options. These options include Original Medicare (traditional fee-for-service Medicare), Medicare managed care plans and the new private fee-for-service Medicare option. Now more than ever, people with Medicare need to understand how Medicare works and the roles that they must play in securing and managing their Medicare coverage in order to obtain the health care they need.

But people with Medicare are not alike. They differ in countless ways, such as their levels of education, their incomes and their cultural backgrounds. These differences affect their ability to understand the options and their capacity to bear the costs of some of the choices. Eighty-four percent of Medicare beneficiaries were non-Hispanic whites in 1998; another 7 percent were African-American; and 6 percent were Hispanic. Significant portions of Medicare beneficiaries are poor. In 1998, 34 percent lived in households with incomes under $10,000, while another 30 percent we in households with incomes between $10,000 and 20,000.¹ (To bring some perspective to these numbers, the federal poverty level for a household of two in 1998 was $10,850). Even more critically, minority populations are growing. By 2020, the proportion of those over age 65 who are white will have dropped to 77 percent. African-Americans and Hispanics will each be 9 percent of those over 65, while 4 percent of seniors will be Asian.²

Cultural differences are some of the most subtle, yet critical, factors affecting how beneficiaries fare under this new requirement that they make a choice from a set of insurance options. Cultural background affects people’s understanding of the concept of insurance, their attitudes towards government programs, their willingness to trust information about Medicare, as well as their capacity to understand the information they receive.
**What’s Happening Now?**

Most of the existing materials that aim to educate people with Medicare about their benefits are written for the “generic” beneficiary. They are in English and generally assume at least an eighth-grade education. Thus, these materials are not optimal for offering information to the many Medicare beneficiaries who speak different languages, have lower levels of literacy or have minimal experience with the American health-care system.

Awareness of the need for culturally appropriate information is growing, however. When resources permit, information intermediaries are beginning to disseminate more diverse materials. The Health Care Financing Administration (HCFA) translates most of its materials into Spanish and provides Spanish-speaking operators on its toll-free telephone hotline. It also offers some materials in Chinese. Through its Horizons project, HCFA is also working with African-American, Hispanic, Asian-American and Native American groups first to adapt existing Medicare information so that it is understandable and accessible, and second to develop the most effective information dissemination strategies for reaching these populations. Both HCFA and the Administration on Aging (AoA) have recently begun the Medicare Empowerment and Collaboration Initiative run through the National Association of Area Agencies on Aging (N4A) and the National Association of State Units on Aging (NASUA). This project seeks to develop new models for educating older adults about Medicare. Many of the funded projects are developing models to reach racial and ethnic minority communities. (For more information on this program, please see the N4A Web site: http://www.N4A.org.)

While critically useful, these materials fall short of the goal to reach all Americans of diverse cultural backgrounds. First, with the exception of the new HCFA/AoA projects, they are usually developed by organizations on the national level. This often means that they are written for cultural communities with large enough numbers of beneficiaries that make the development of such specialized materials economical. Smaller ethnic communities, such as Korean or Polish immigrants, often get overlooked. Second, many of the materials are simple translations of documents in English; they do not change the information to include more culturally appropriate concepts or imagery. Thus, beneficiaries still might not find them applicable or useful in decision making.

**The Working Group on Culturally Appropriate Medicare Education**

In December 1999, the Center for Medicare Education (CME) organized the Working Group on Culturally Appropriate Medicare Education, whose purpose was to develop culturally appropriate Medicare education resources through partnerships with national and local organizations representing different ethnic communities. To organize the group, the CME identified the four most populous ethnic minority groups among Medicare beneficiaries: African-Americans, Asian and Pacific Islanders, Latinos/Hispanics and Native Americans. The group used network contacts to choose organizations that represent those four groups and had prior interest and experience in working on Medicare issues. After numerous discussions and an initial meeting with several organizations, the CME formed partnerships with the National Asian Pacific Center on Aging (NAPCA) and The Spanish Speaking Elderly Council-RAICES (RAICES). The CME gave small grants to the organizations and provided access to technical consultants with expertise in health information, literacy, mass media and cultural competence.

NAPCA and RAICES were charged with developing materials or outreach strategies to provide information to their communities about any of the major aspects of the Medicare program: Original Medicare, Medicare managed care or the Medicare Savings Programs—i.e., the Qualified Medicare Beneficiary (QMB), Specified Low-income Medicare Beneficiary (SLMB), or Qualified Individual (QI) programs. The materials or outreach could be in either traditional print form or audio or video media. In October 2000, the organizations reconvened to present their work and the process by which it had been created.

**The Results**

The working group’s efforts resulted in the development of several different types of prototypes of educational materials for the Latino and Vietnamese communities.
They found that the majority of Latino seniors knew that they were entitled to Medicare and knew how to enroll in Medicare. They did not know, however, about various Medicare coverage options such as Medigap insurance or Medicare managed care. RAICES staff therefore began to focus on materials that would raise the level of awareness of the existence of the different parts of the Medicare program.

Many Hispanic elders have low levels of literacy and prefer to get their information from radio and television. Staff therefore decided to write PSAs for those sources of information and ask Latino seniors for comments. They then worked with technical consultants from the radio and cable TV industries to turn their drafts into PSA prototypes.

The PSA scripts had several features that geared their messages toward Hispanic elders. First, the television PSA was designed to be run during the airing of "novellas," the Spanish-language soap operas that are extremely popular with Hispanic older adults. In order to fit in with its soap opera context, the PSA was a small play with a story line.

Juana: Pero que té pasa.
Maria: Na’ es que tengo que registrarme pa’l Medicare y hay tanta información que estoy confusa.
Juana: Pero de qué información tu estas hablando.
Maria: Mira lo que pasa es que ahora hay tantas opciones que no se que escoger. Que si Medicare Original, que si cobertura suplementaria, que si un HMO, que si Medigap; y lo de los medicamentos ni hablar.
Juana: Ay mi’ja no te preocupes por eso. Te acuerdas de Carmen la vecina del 5to piso, ella pasa por lo mismo, pero llamo a RAICES. Tu sabes que esa es la agencia que ayuda a las personas mayores como nosotros a conseguir servicios y beneficios. Llámalos y veras que te resuelven el problema.

Juana: What is wrong?
Maria: I need to register in the Medicare program but there is so much information that I’m confused.
Juana: But tell me, what information are you talking about?
Maria: Look, what happens is that now there are so many options under Medicare that I don’t know which one to choose! They talk about original Medicare, Medicare with supplemental coverage, Medigap; and I don’t want to start on the medication coverage.
Juana: Don’t worry about that. Do you remember Carmen, our neighbor who lives on the 5th floor, she was going through the same thing, but she called RAICES. You know, the agency that helps older adults like us to get services and benefits. Call them and you’ll see that they’ll take care of you.
English-language PSAs, oriented toward the generic population, often present authority figures providing information on a social problem, rather than a story. The second distinctive cultural feature of the Spanish-language PSA was that both characters were Medicare consumers. They were peers of the viewers, rather than public officials. This feature was intended to build familiarity and trust among Hispanic viewers. The radio PSA also had some specific cultural features, such as the use of a personal introduction. The radio PSA narrator identifies himself by his name and title. This is intended to appeal to the Hispanic preference for relations that embody “personalismo” where information is delivered through personal contact, rather than official (impersonal) channels.

NAPCA

For its part of the working group, NAPCA created bilingual English/Vietnamese posters and brochures explaining Medicare, Medicaid and the Medicare Savings Programs. Many Vietnamese elders immigrated as older adults and thus may not have sufficient Social Security tax contributions to qualify for premium-free Medicare Part A. NAPCA produced bilingual materials because many Vietnamese seniors rely on their English-speaking children to help them with their Medicare decisions. (For an excerpt of the brochure, see Figure 2.) NAPCA found that the Vietnamese elders preferred the poster and brochure to a multi-page booklet because such formats were less intimidating for elders with low literacy levels. Posters encouraged readers to get all the information in one session. Brochures were easily folded and placed into a pocket or a purse to be taken home and read with family members or friends.

To produce these materials, NAPCA created a nine-member translation team. The members were from different Vietnamese organizations (e.g., a civic association and a nutrition program for seniors) in order to assure that varied age and socioeconomic perspectives would be tapped during the development of the prototype materials. The purpose of the team was to translate basic information into Vietnamese, assure that content and vocabulary were appropriate, and give input on format and design. Individual team members were assigned to produce portions of the text in Vietnamese, which were then reviewed by two other team members. The text was then discussed by the entire team in conference calls. The resulting document was field tested in programs for Vietnamese seniors in Massachusetts and Virginia.

![Figure 2](Image)

**Excerpt from NAPCA Brochure**

<table>
<thead>
<tr>
<th>Program</th>
<th>Monthly Income Limits*</th>
<th>Asset Limits**</th>
<th>For Year 2000</th>
</tr>
</thead>
<tbody>
<tr>
<td>QMB</td>
<td>$ 716 $ 958</td>
<td>$ 4,000 $ 6,000</td>
<td>Medicare Premiums, Deductibles and Co-Insurance</td>
</tr>
<tr>
<td>SLMB</td>
<td>$ 855 $ 1,145</td>
<td>$ 4,000 $ 6,000</td>
<td>Medicare Part B Premium</td>
</tr>
<tr>
<td>QI-1</td>
<td>$ 960 $ 1,286</td>
<td>$ 4,000 $ 6,000</td>
<td>Medicare Part B premium</td>
</tr>
<tr>
<td>QI-2</td>
<td>$ 1,238 $ 1,661</td>
<td>$ 4,000 $ 6,000</td>
<td>$2.23 per month towards your Medicare Part B premium</td>
</tr>
<tr>
<td>Medicaid***</td>
<td>$ 559 $ 810</td>
<td>$ 2,000 $ 3,000</td>
<td>All medical expenses not covered by Medicare</td>
</tr>
</tbody>
</table>

**EXPLANATION:**
- *Income* includes Social Security checks, interest, wages, VA benefits and retirement benefits. Income limits will vary every April.
- **Assets** include cash, bank accounts, certificate of deposits, stocks, bonds, Individual Retirement Accounts, property other than your home and one vehicle.
- ***Medicaid*** limits may be higher in some states.

<table>
<thead>
<tr>
<th>Chuong trinh</th>
<th>Giới hạn lợi tức (tháng)*</th>
<th>Tái sản tối đa**</th>
<th>2000</th>
</tr>
</thead>
<tbody>
<tr>
<td>QMB</td>
<td>$ 716 $ 958</td>
<td>$ 4,000 $ 6,000</td>
<td>Lê phí hàng tháng, tiền khẩu trích và phần đóng góp của mình</td>
</tr>
<tr>
<td>SLMB</td>
<td>$ 855 $ 1,145</td>
<td>$ 4,000 $ 6,000</td>
<td>Lê phí hàng tháng Phần B</td>
</tr>
<tr>
<td>QI-1</td>
<td>$ 960 $ 1,286</td>
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<td>$ 1,238 $ 1,661</td>
<td>$ 4,000 $ 6,000</td>
<td>$2.23 cho lệ phí hàng tháng Phần B</td>
</tr>
<tr>
<td>Medicaid***</td>
<td>$ 559 $ 810</td>
<td>$ 2,000 $ 3,000</td>
<td>Tái sản tối đa là mức Medicare không trả</td>
</tr>
</tbody>
</table>

**GIẢI THÍCH:**
- Lợi tức bao gồm tiền an sinh xã hội, tiền lợi cho vay, tiền lương, phụ cấp và chi phí bệnh jakie, và tiền hưởng trợ. Giới hạn lợi tức sẽ thay đổi vào tháng 4 mỗi năm.
- **Tái sản** bao gồm tiền mặt, chứng từ ngân hàng, tiền giữ tiết kiệm, cổ phần chứng khoán, trái phiếu, chứng từ mua trái phiếu xã hội, các tài sản khác không kể cá nhân và một chiếc xe của quý vị.
- ***Giới hạn lợi tức để được hưởng Medicaid tại một số tiêu chuẩn có thể cao hơn.**
Lessons Learned

Culturally appropriate Medicare education is more than translation. Cultures differ in more than just the language they use to express words; they also differ in the ways a person views the world and, thus, the types of information that may be relevant and necessary for him or her to learn. People with Medicare who were born and raised in societies where the concept of insurance is not widely known such as Central America or Southeast Asia, have difficulties understanding and navigating their way through a system that includes co-insurance, risk management and prepayment. Materials bent on educating them about the health-care system must include very basic definitions about such elements and use ideas that are related to cultural experiences. Both RAICES and NAPCA found that direct translations of English-language materials often did not make sense to their audiences. Writing scripts in English and then translating them into Spanish, as RAICES originally did, failed to produce meaningful content. As a result, both came to the conclusion that they needed to develop materials in their own languages, using culturally accepted concepts, and then translate them into English.

Messages also need to focus on the specific circumstances of the audience. NAPCA and RAICES found that for cultures, such as Hispanic and Vietnamese, where intergenerational family structures are strong, older adults need to understand that Medicare (at least Original Medicare) can be used if they travel from state to state to stay with different adult children. However, it is also important to let them know that Medicare cannot be used if they travel back to their “home” country.

Cultures also contain different understandings about the messages implied by the use of various images or types of graphic designs. The Biblical prohibition against “graven images” that guides the art of some ethnic groups is one example of such a cultural standard. Certain colors have meanings in some cultures; cartoons, sketches and photographs have certain meanings in others. The team that developed the NAPCA project recommended the use of the color brown for the text since it reminds older people of the earth and is a peaceful color.

Finally, cultures have implicit and explicit guidelines about appropriate and inappropriate ways to disseminate information. Messages often get combined with the messengers. Some communities are more inclined to respond to information if it is disseminated in specific, culturally appropriate ways. Staff from RAICES, for example, did not begin their Medicare education workshops and focus groups until they had individually addressed each senior in the room and spent time conversing about daily matters. Hispanic culture emphasizes the value of social conversation as a prelude to the distribution of information. Along similar lines, NAPCA considered distributing Medicare information on a calendar. Vietnamese elders often keep a calendar in a central part of their homes because it is useful for identifying the anniversary dates of their ancestors’ deaths and thus of help in their religious observances.

Keeping these points in mind, culturally appropriate Medicare education can take on several forms:

- Translation of materials into other languages.
- Use of culturally relevant concepts in the content of the materials.
- Use of graphic design to reflect cultural preferences.
- Use of alternative media, such as mass media rather than print materials, to reflect cultural preferences.
- Use of culturally specific outreach or information dissemination strategies.

The differences within ethnic groups are as important—and as difficult—to deal with as the differences among ethnic groups. Most of the commonly recognized ethnic groups in the United States are composed of people from more than one country. Hispanics or Latinos come from Mexico, the Caribbean and Central and South America. Asian-Americans consist of Koreans, Japanese, Chinese and Southeast Asians, among others. African-Americans are native to the United States and also from Africa and the Caribbean. Most of these subgroups have their own culture and language or dialect. These differences require educational methods that translate words and concepts not only to another language, but to several other languages. RAICES had to spend much of its time negotiating among various subgroups in order to find words that meant the same thing in all of the
dialects of Spanish for each Hispanic group. The NAPCA team dealt with 30 different Vietnamese dialects, as well as clear difference in language between Vietnamese older adults from urban and rural areas.

Ethnic communities also may be internally divided in terms of the era in which people emigrated to the United States. Those developing culturally appropriate materials must understand and deal with the differences among these different generations. NAPCA had to create materials using language that was relevant to those who emigrated directly from Vietnam in the last decade and those who came over as refugees immediately after the Vietnam War. Each of these groups has different attitudes toward the role and trustworthiness of government and thus reacts differently to educational materials about government-sponsored programs.

The process through which educational materials are developed needs to be guided by cultural expectations and behaviors. Both NAPCA and RAICES found that cultural values affected the way they developed materials. Among the Vietnamese, for example, it is impolite to criticize another person’s work because such actions threaten group harmony. The team from NAPCA, therefore, had to work hard to develop guidelines for the discussion and review of prototype materials that encouraged suggestions for changes without violating that cultural boundary. They found that the process worked best when the NAPCA staff coordinator followed up each conference call with individual telephone calls to each member. These latter calls allowed team members to work through their comments in a more private setting. Similarly, RAICES found that Hispanic seniors strongly believed that it was disrespectful to comment on the work of people in authority. RAICES staff therefore withdrew from the sessions where feedback on the draft materials was requested from older adults and asked staff at each of the senior centers to collect this feedback. Since these staff were not the outside experts, the older people gave their feedback more freely.

The Need for Partnerships

To succeed in creating educational materials that make sense in another culture, we have learned that people developing these materials must have not only a deep understanding of the implicit meanings of words and images, but also a grounded understanding of how to present the information to the target audience. Thus partnerships between aging and/or consumer organizations and community-based social service organizations representing various ethnic communities may be useful mechanisms for developing effective Medicare education materials and may be mutually beneficial for both organizations. Aging organizations often have in-depth knowledge of Medicare, and community-based ethnic organizations typically have substantial knowledge of the appropriate ways to educate their members. However, these partnerships offer both challenges and advantages.

THE CHALLENGES

- Cross-cultural work increases the demands on the staff of both organizations. Working through cultural differences and forging an understanding of how each group views the world can be time intensive and emotionally charged for staff on both sides of the partnership.

- Different orientations or priorities can create tension between the partners. Aging groups are concerned with maintaining the functioning of older people in the community. Thus they are more likely to focus on social service and medical programs and issues. In contrast, ethnic community organizations often must represent all generations and therefore tend to focus on issues that are relevant to the entire age structure (e.g., affordable housing).

- Many community-based organizations (CBOs) operate on very small budgets. They usually depend on funding earmarked for the provision of social services. They therefore have little time and even less money to devote to the development of educational materials. Maintaining the momentum to complete the project can be difficult. Partnering organizations should think about providing funding to the ethnic CBOs to enable them to devote staff time to the education project.

- The process of developing attractive educational materials is costly in terms of raising the demand
for individual counseling and additional materials. Therefore, both aging organizations and ethnic CBOs may be reluctant to generate demand that they cannot satisfy because of limited resources.

Because aging or consumer organizations and CBOs are often so resource poor, they pursue funding with great intensity. Given the perennial lack of funding for services to the aging and minority communities, these organizations often are direct competitors. This can hinder the creation and maintenance of partnerships.

THE ADVANTAGES

Partnerships generate more “buy-in” by the ethnic community because the trusted organization(s) that have served them in the past have been involved in the development of the materials. Outreach and dissemination are likely to be more successful because they are being undertaken with the leadership/involvement of an organization from the community itself.

Partnerships improve the capacity of both parties to undertake their work. Aging organizations can become more knowledgeable about the lives and beliefs of ethnically diverse seniors in their communities and more competent in dealing with their needs, while organizations that serve ethnic communities can become more expert in issues of aging and aging policies.

Partnering on Medicare education increases the capacity of the entire local community to tackle other social issues. Partnerships to create Medicare education materials can be expanded to partnerships to deal with other issues, like the local transportation system or the hours of a local clinic. Government agencies or private service providers are often more likely to respond to community groups that represent larger portions of the community.

Additional Resources

Ethnic organizations that work in the area of aging and/or health-care issues:

**NATIONAL HISPANIC COUNCIL ON AGING**
(202) 265-1288
http://www.nhcoa.org

**NATIONAL ASIAN PACIFIC CENTER ON AGING**
(206) 624-1221
http://www.napca.org

The “Help for Health” section of the Web site includes PDF versions of various Medicare education publications, including “Medicare Benefits” and “Medicare and QMB” in Asian languages such as Chinese, Vietnamese, Korean and Tongan.

**NATIONAL INDIAN COUNCIL ON AGING**
(505) 292-2001
http://www.nicoa.org

**NATIONAL CAUCUS AND CENTER ON BLACK AGED**
(202) 637-8400
http://www.ncba-blackaged.org

**NATIONAL ASSOCIATION FOR THE ADVANCEMENT OF COLORED PEOPLE**
(410) 521-4939
http://www.naACP.org

**NATIONAL ASSOCIATION FOR THE HISPANIC ELDERLY (ASOCIACION NACIONAL POR PERSONAS MAYORES)**
(213) 487-1922
http://www.anppm.org

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About the Authors

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Additional Resources

Other Web resources on cultural competence and health education:

RESOURCES FOR CROSS CULTURAL HEALTH CARE
http://www.diversityrx.org/HTML/DIVRX.htm
The site contains a medical interpretation resources and references list, a multicultural health-care best practices overview and other health-related information.

CULTURAL COMPETENCE RESOURCES
http://www.airdc.org/cecp/cultural/resources.htm
Includes general information, organizations, policy resources, implementation resources and training guides, along with a calendar of upcoming cultural competence events.

CROSS CULTURAL HEALTH CARE PROGRAM
http://www.xculture.org/
This organization “serves as a bridge between communities and health care institutions to ensure full access to quality health care that is culturally and linguistically appropriate.” The Web site is packed with information on a variety of resources for translation and interpreter services, training programs and updates on current health issues.

ETHNOMED
http://healthlinks.washington.edu/clinical/ethnomed/htopics.html
This site, sponsored by the University of Washington, provides information about cultural beliefs, medical issues and other related issues pertinent to the health care of recent immigrants to Seattle (mostly southeast Asian and East African groups).

ACHIEVING CULTURAL COMPETENCE: A Guidebook for Providers of Services to Older Americans and Their Families
This guidebook includes resources on cultural competence and the development of culturally appropriate programs. (PDF and WordPerfect versions of the guidebook can be downloaded through this site.)

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Fax: 202-783-4266
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